DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11037 (Rev. 06/03)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions (HCF 11037A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Requesting / Performing Provider

5. Telephone Number — Requesting / Performing Provider

6. Name — Referring / Prescribing Provider

7. Referring / Prescribing Provider's Medicaid Provider Number

SECTION III — DOCUMENTATION

8. Describe length and intensity of treatment requested.

- Program request is for _____ hours per day,
  _____ days per week,
  for _____ weeks,
  for a total of _____ hours.
- Anticipated beginning treatment date _____.
- Estimated substance abuse day treatment discharge date _____.
- Attach a copy of treatment design, which includes the following:
  a. A schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  b. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form).

9. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures which were employed.

Continued

SECTION III — DOCUMENTATION (Continued)

10. List recipient's **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

11. Describe the recipient's **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance(s) abused, amounts used, date of last use, etc.)

12. Has the recipient received any substance abuse treatment in the past twelve months? ❑ Yes ❑ No
If "Yes," provide information on date of each treatment episode, type of service provided, and **treatment outcomes**.

13. Has the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months? ❑ Yes ❑ No
If "Yes," give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

Continued

SECTION III — DOCUMENTATION (Continued)

14. Describe the recipient's severity of illness using the following indicators. Individualize all information.

a. Loss of control / relapse crisis.

b. Physical conditions or complications.

c. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.)

d. Recovery environment.

e. Life areas impairment. (Specify social / occupational / legal / primary support group.)

f. Treatment acceptance / resistance.

15. Treatment Plan

- **Attach** a copy of the recipient's substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria).
- Describe any special needs of the recipient and indicate how these will be addressed (for example, educational needs, access to treatment facility).

- Describe the recipient's family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not.

Continued

SECTION III — DOCUMENTATION (Continued)

15. Treatment Plan (Continued)

- Briefly describe treatment goals and objectives in specific and measurable terms.

- Describe the expected outcomes of treatment including the plan for continuing care.

I have read the attached request for PA of substance abuse day treatment services and agree that it will be sent to Wisconsin Medicaid for review.

16. **SIGNATURE** — Recipient or Representative	17. Date Signed
18. Relationship (if representative)	

Attach a photocopy of the physician's current prescription for substance abuse day treatment. (Must be dated within one month of receipt at Wisconsin Medicaid.)

19. **SIGNATURE** — Performing Provider	20. Date Signed
21. Discipline of Performing Provider	
22. **SIGNATURE** — Supervising Physician or Psychologist	23. Date Signed
24. Supervising Physician or Psychologist's Medicaid Provider Number	

Reset Form